CLINICAL ETHICS

''Idiots, infants, and the insane'': mental illness and legal incompetence

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Prior to the second world war, most persons confined in insane asylums were regarded as legally incompetent and had guardians appointed for them. Today, most persons confined in mental hospitals (or treated involuntarily, committed to outpatient treatment) are, in law, competent; nevertheless, in fact, they are treated as if they were incompetent. Should the goal of mental health policy be providing better psychiatric services to more and more people, or the reduction and ultimate elimination of the number of persons in the population treated as mentally ill?

Contemporary medicine and law define mental illness as an ''illness like any other illness''.[1] The person diagnosed as mentally ill (and dangerous to himself or others) is, however, deprived of liberty, a procedure called ''civil commitment'' in the US, and ''sectioning'' in the UK.

Black's Law Dictionary defines incompetence as the ''legal status of a person who is unable or unfitted to manage his own affairs...and for whom, therefore, a committee may be appointed''.[2] It is the function of the court (judge) to appoint a legal guardian for the incompetent person; such a guardian has clearly defined fiduciary duties to protect the best interests of his ward.

In principle, the mental patent is considered competent (until proven incompetent). *In practice,* he is regularly treated as if he were incompetent and the psychiatrist who asserts that he needs treatment is treated as if he were the patient's guardian.[3] This conflation of mental illness and legal incompetence, and the concomitant transformation of the mental hospital patient into ward and the psychiatrist into guardian, is a relatively recent phenomenon.

When I was a medical student in Cincinnati in the early 1940s, there were no voluntary patients in Ohio state mental hospitals. A person could no more gain admission to a state mental hospital voluntarily than he could gain admission to a prison voluntarily. Individuals civilly committed to state mental hospitals were considered legally incompetent. They were released, however, if their next of kin was willing to care for them.

In the UK, too, until recently, the person confined in a mental hospital was assumed to be legally incompetent. Prior to the English *Mental Health Act 1983*, it was generally assumed that psychiatric detention automatically authorised the psychiatrist to treat the patient without consent. The act explicitly authorised the treatment of detained patients without their consent.

In the aftermath of the second world war, American social attitudes toward mental hospitalisation began to change, partly as a result of the extermination of mental patients in Nazi Germany. Journalists compared state mental hospitals to concentration camps and called them ''snake pits''. Erving Goffman's book, *Asylums*,[4] and my book, *The Myth of Mental Illness*,[5] challenged the moral and legal legitimacy of psychiatric coercions, exemplified by involuntary confinement in a mental hospital. Presidents of the American Psychiatric Association and editors of psychiatric journals acknowledged the problem of chronic mental patients becoming ''institutionalised''.

At this critical moment, the psychiatrists' drugs miraculously appeared and saved the profession. At least for a time. Politicians and the public quickly accepted the psychiatrists' claim that mental illnesses were brain diseases (''chemical imbalances''), and that neuroleptic drugs are effective treatments for such diseases. Psychiatrists and politicians used this fiction as a peg on which to hang the complexly motivated programme of emptying the state mental hospitals, misleadingly called ''deinstitutionalisation''.[6] In short, the three events characteristic of modern psychiatry—the development of psychiatric drugs, deinstitutionalisation, and the conflation of mental illness and legal incompetence—occurred in tandem, each facilitating and supporting the others.

Actually, the treatment of mental diseases is no more successful today than it was in the past. Deinstitutionalisation did not liberate mental patients. Some state mental hospitals inmates were transinstitutionalised, rehoused in parapsychiatric facilities, such as group homes and nursing homes. Others were imprisoned for offences they were prone to commit, transforming jails into the nation's largest mental hospitals. Still others became ''street persons'', living off their social security disability benefits. Most idle, indigent, unwanted persons continue to be incarcerated in mental hospitals—intermittently, committed several times a year, instead of once for decades.

Most importantly, the powers of courts and mental health professionals were vastly expanded: before the second world war, they could control and forcibly ''treat'' only persons housed in mental hospitals. Armed with ''outpatient commitment'' laws (in the US), psychiatrists can now control and forcibly ''treat'' persons living in the community.

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Medical practices rest on consent. Psychiatric practices rest on coercion, actual or potential. It is the power and duty to coerce mental patients—to protect them from themselves and to protect society from them—that has always set, and continues to set, psychiatrists apart from other medical practitioners. Nevertheless, the conflation of mental illness and legal incompetence—redescribed as ''protection of the patient's best interest''—is widely regarded as an important advance in medical and psychiatric ethics.

MENTAL ILLNESS IS NOT SYNONYMOUS WITH LEGAL INCOMPETENCE

In the old days of asylum psychiatry, the connection between mental illness and legal incompetence was unambiguous. If a person was mad enough to merit confinement in a madhouse, then he was manifestly incompetent. Whereas if he was competent, then he was manifestly not a fit subject for incarceration in an insane asylum.

After the second world war, the treatment of ''mental illness'' by psychoanalysis and psychotherapy achieved sudden popularity. The introduction of neuroleptic drugs into psychiatry created the illusion that mental illnesses, like medical illnesses, were ''treatable'' with drugs. Doubt about the benefits of long term mental hospitalisation was replaced by confidence in the effectiveness of outpatient chemotherapy for mental illness. A new class of mental patients thus came into being—persons who sought psychiatric help, paid for the services they received, and were regarded as legally competent. In these important ways, they resembled medical patients. This development greatly enlarged the number of persons classified as mentally ill, contributed to the false belief that legal competence is a psychiatric issue, and confused the legal relations between psychiatrist and mental patient.

Two troubling facts continue to bedevil psychiatry and especially the increasingly important field of forensic psychiatry—namely, that we lack objective tests for both mental illness and mental (legal) competence. Competence and incompetence—like innocence and guilt—are *attributions,* not *attributes, judgments*, not *facts*. That is why traditionally they are rendered by lay juries, not professional experts.

In general, the psychiatric patient whose behaviour is socially deviant risks being considered incompetent (as well as mentally ill). If—for example—the patient kills herself or someone else, then, after the fact and simply for this reason, she is considered incompetent and her psychiatrist's treatment of her is judged to be ''medically negligent'': the psychiatrist, viewed as the patient's guardian, is considered to have failed to fulfil his ''duty to protect'' his ward. None of this was true as recently as the 1960s.

The conflation of mental illness and legal incompetence entangles both patients and psychiatrists in Alice in Wonderlandish encounters, as the following example illustrates. On December 7, 1981, a man named Darrell Burch was found wandering along a Florida highway, appearing to be disoriented. Taken to Apalachee Mental Health Services (ACMHS) in Tallahassee, his evaluation form stated that: ''upon arrival at ACMHS, Burch was hallucinating, confused, and psychotic and believed he was 'in heaven'''.[7] Burch was asked to sign forms giving consent to admission and treatment and did so. Diagnosed as suffering from paranoid schizophrenia, he was given psychotropic medication.

Subsequently, Burch was transferred to the Florida State Hospital (FSH) in Chattahoochee and again asked to sign, and did sign, forms giving consent to hospitalisation and treatment. At the FSH, a staff physician named Zinermon ''wrote a progress note indicating that Burch was refusing to cooperate and would not answer questions'' (Zinermon *v* Burch,[7] p 119).

Burch remained at the FSH as a ''voluntary'' patient for 5 months. After he was released, he sued Zinermon and 10 other staff members of the FSH for having deprived him of liberty without due process of law, *because he was mentally incompetent to consent to hospitalisation and treatment*. The case was appealed all the way to the United States Supreme Court, which ruled that when Burch was admitted to the FSH, he was incompetent and hence had a constitutionally protected right to a court hearing to determine whether he should be committed and treated as an involuntary patient:

> [T]he very nature of mental illness makes it foreseeable that a person needing mental health care will be unable to understand any proffered ''explanation and disclosure of the subject matter'' of the forms that the person is asked to sign, and will be unable ''to make a knowing and willing decision'' whether to consent to admission....*The characteristics of mental illness thus create special problems regarding informed consent. Even if the State usually might be justified in taking at face value a person's request for admission to a hospital for medical treatment, it may not be justified in doing so, without further inquiry, as to a mentally ill person's request for admission and treatment at a mental hospital* (*Zinermon v Burch*,[7] pp 121 and 133, emphasis added).

The court's ruling upset the psychiatric establishment. Bruce J Winick, a professor of law at the University of Miami, complained that ''the court's language could have unintended *antitherapeutic consequences*'' (emphasis added).[8] This cliché assumes that the purpose of depriving insane persons of liberty is therapy, which, given the dangerousness clause in commitment laws, is patently false.

DISPOSITIVE TERMS DECREE, THEY DO NOT DESCRIBE

In order to conduct relations with individuals we do not know, we must make certain *presumptions* about them. The automobile dealer must presume that his customer is legally competent and responsible for his purchase. The physician whose patient complains of blood in his stool must presume that the patient has a disease. The Anglo-American legal system *must presume* that a person accused of a crime is innocent until proven guilty, and competent until proven incompetent.

We are proud of our criminal justice system because it protects the accused from the power of the state, a power we distrust because its avowed aim is to harm the individual. Similarly, we are also proud of our mental health system, because it protects the mentally ill person from the dangers he poses to himself and others, a power we trust because its avowed aim is to help the individual.

Difficulties arise, however, once the power of the state to ''help'' goes beyond offering services (or money) and, instead, the state makes use of coercion. The justification for psychiatric coercion is further weakened by resting the requirement for commitment on ''mental illness'' and ''dangerousness''. There are no objective criteria for either mental illness or dangerousness. Thus psychiatric determinations and declarations of their presence or absence are essentially *oracular* and *rhetorical*. Nevertheless, they fulfil a very important function: they instruct the listener to assume a desired attitude toward the ''patient''.[9] The distinction between descriptive and dispositive terms is crucial for understanding this conundrum.

Characterising a door as brown or white is *descriptive*. Characterising it as needing to be opened or closed is *dispositive*. Descriptive characterisations can be proved or

disproved. Dispositive characterisations cannot, they can only be obeyed or disobeyed. The difference between the situation of the person accused of a crime and the situation of the person accused of mental illness is illuminating. The defendant has a right to deny his crime and disagree with his accusers. His insistence on his innocence is not interpreted as evidence of his guilt. The person diagnosed as mentally ill loses this right. His disagreement with the psychiatrist is interpreted as ''lack of insight into his illness'' or ''denial of his illness''. His insistence on his sanity is interpreted as evidence of his insanity.

Psychiatrists use the term ''competent'' as if they were identifying a ''mental condition'' *in* the designated person. That is why courts request the psychiatrist to *examine defendants for competence, as if they were looking for and detecting (or not detecting) certain facts*. Psychiatric ''findings,'' however, especially in a forensic setting, *are not facts but recommendations for a course of action toward the defendant.*

Ironically, it is precisely because the American system of criminal justice is so intensely concerned with protecting innocent persons from punishment that it is especially vulnerable to corruption by excuses couched in terms of psychiatric disabilities and coercions justified as psychiatric treatments. The root of the problem lies largely in the concepts of mental illness and dangerousness, and partly in the doctrine of *mens rea*, sound mind.

Because both ''mental illness'' and ''dangerousness'' lack objectively verifiable criteria, they are easily abused.[9]

The legal doctrine of *mens rea,* sound mind, which holds that unlawful behaviour constitutes a crime only if it is committed by an actor who possesses a ''guilty mind''—that is, whose ''mind'' can be held responsible (because it knows right from wrong), also works to strip the person incriminated as mentally ill of his rights. Since the Middle Ages and before, insane persons—perceived as similar to ''wild beasts''—have been regarded as lacking *mens rea*. This is why ''infants, idiots, and the insane''—in John Locke's famous phrase, repeated unchanged ever since—are not prosecuted or punished by the criminal law, but instead are restrained, as minors and as mad, by family courts and mental health laws.

Treating mentally ill persons as if they were like children fails to take into account the many obvious differences between them. Minority is an objectively defined (chronological) condition and a legal status. Mental illness is neither. Children are, by definition, under tutelage. Few mental patients are under tutelage and those that are, are in that status not because they are mentally ill but because they are declared to be legally incompetent.

Persons called ''mental patients'' are not children and are not like children. They are adults, entitled to liberty and responsible for their crimes. I maintain that ''mental illness'' is not something the patient has, it is something he is. The modern psychiatrist is likely to view Lady Macbeth as insane, the victim of manic depressive psychosis, an illness that renders her not responsible for her crimes. Shakespeare viewed her as ''Not so sick...as troubled with thick coming fancies'', for which she needs ''the divine [minister, rather] than the physician''.[10]

The very survival of psychiatry as a medical specialty depends on postulating and perceiving ''mental illness'' as a disease, an entity ''outside'' and separate from the patient as a moral agent, in the sense that, say, malaria, in a European tourist returning from Africa, is ''outside'' and separate from his persona.[11]

In an interesting recent paper, Sadler and Fulford struggle with this issue and propose that, in formulating criteria for psychiatric diagnoses (but not for medical diagnoses), psychiatrists include the opinions of mental patients and their relatives. They write: ''Why should psychiatry involve patients in diagnosis? A key part of psychiatric treatment, rehabilitation, and recovery is *helping the patient to distinguish between the features of illness and the features of the self—to move patients from battling themselves to battling their disorders*'' (emphasis added).[12]

A hundred years ago, psychiatric nosology was the province of the neuropathologists: by definition, mental diseases were brain diseases, identified at autopsy and demonstrated by histological evidence. The purpose of a diagnosis—medical and psychiatric alike—was to convey scientific information. Since then, without anyone quite realising it, neuropathological diagnostic criteria were transformed into psychopathological diagnostic criteria, and the reasons for making psychiatric diagnoses have expanded and now serve a vast number of complex economic, political, social, and other non-scientific ends.

Regarding Sadler and Fulford's therapeutic aim of ''moving patients from battling themselves to battling their disorders'', it is necessary to note that everyone harbours contradictory desires and thus everyone may be said to be battling himself. Psychiatrists accentuate the metaphor of ''inner battle'', while they avert their gaze from the bitter reality of the ''outer battle'', the battle between the involuntary mental patient and ''his'' psychiatrist. I dare say that that embarrassing spectacle is our profession's ''elephant in the room''. The need to pretend that it is not there is the most important unwritten rule of psychiatric etiquette.[13]

MENTAL ILLNESS AND MENTAL CAPACITY: RHETORIC AND REALITY

In legal theory, mental illness and mental incapacity are separate issues. In psychiatric practice, they are the same issue.

In *Re C* (1994), the English High Court held that detained patients were entitled to the presumption of competence: a hospitalised patient with schizophrenia was considered competent to refuse amputation of his gangrenous foot. Had the patient sought to refuse drug treatment for schizophrenia, his decision could have been overruled and he could have been medicated against his will.[13]

> In a 1999 review article in the *BMJ*, Barbara Hewson, a London barrister, concluded that: A person may remain competent even if detained under the *Mental Health Act 1983*....Adults are presumed competent to refuse treatment, even in an emergency; but it is not easy to judge in practice what factors are capable of rebutting the presumption. Every case turns on its own facts. The detention of incompetent patients for treatment...is controversial, and likely to generate litigation under the *Human Rights Act 1998*.... the law in this area is complex.[14]

I believe the law in this area is not just complex, it is not true law at all: absent objective criteria for the key concepts, *decisions about competence and the right to reject psychiatric treatment*, remain in the hands of psychiatrists. This gives psychiatrists both too much power and too much responsibility.[15]

In a reply to Hewson's article, a Canadian psychiatrist complained: ''After reading Hewson's article I was more confused than ever. No matter what is decided, to treat or not treat, a doctor has the pleasure of looking forward to an assault charge or wilful negligence. This entire debate is ludicrous. The law should be changed so that a self harm is viewed as a declaration of incompetence''.[16] This respondent can think of no better solution than to revert to the ''good old

days of psychiatry'': restore absolute medical power over mental patients to psychiatrists, complemented by legal immunity for the consequences of their decision.

In a 2002 editorial in *The Psychiatric Bulletin*, Vanessa Raymont, an English psychiatrist, reminds us:

> Although the notion of informed consent was recognised in medical practice as early as the 1700s, it was not until the advent of the voluntary boarder status in the *Lunacy Act 1890* and the voluntary patient in the *Mental Treatment Act 1930* that the issue of capacity and consent for psychiatric treatments was first raised in non-detained patients....The *Mental Health Act 1983* allows treatment without consent in psychiatric illness, but not physical illness.[17 18]

Decisions by the European Court of Human Rights (ECHR) regarding complaints of psychiatric deprivations of human rights further illustrate the discrepancy between legal theory and psychiatric practice. A woman in the Netherlands voluntarily entered a psychiatric hospital. A month later, a judge, without notifying the patient, confined her to the hospital for 6 months without holding a hearing. The ECHR ruled that the defendant/patient's ''right to a speedy trial or hearing applies to both criminal arrests and psychiatric detentions and hence the patient's rights were violated''.[19]

ON PSYCHIATRIC ''REFORM''

It is inevitable that many persons in society—infants and young children, severely retarded individuals, demented and unconscious patients—must be treated as legally incompetent. This is not true for mental patients.

The ostensible motive behind recent so called mental health reforms has been the desire to free the mental patient from anachronistic, authoritarian psychiatric controls. Certain crass psychiatric coercions—such as indefinite involuntary mental hospitalisation, beatings, and cold showers—have become unfashionable. Yet, changes in mental health policy have failed to increase the mental patient's responsibility to care for himself, to be accountable for his everyday behaviour, and to be legally answerable for his criminal conduct. On the contrary, today more people than ever are defined as mental patients and are ''treated'' without their consent, as if they were incompetent. More worryingly, the coercive practice of commitment, formerly confined to the mental hospital, has metastasised: outpatient commitment has turned all of society into a kind of mental hospital.

We cannot make progress in mental health care policy until we clarify and agree on what we mean by progress. Psychiatrists and politicians mean by it making more and better mental health services available to more and more people. I consider that to be not progress, but a plan to turn more people into ''consumers of mental heath services''. There can be only one humane goal for mental health care policy, namely, reducing and ultimately eliminating the number of persons in the population treated as mentally ill. We cannot attain this goal—indeed, we cannot even begin to pursue it—as long as we cling to the notion that ''mental illness'' is a disease that the patient ''has''.

Mental illness may look like an illness and may be called an illness, but it is not a true illness. Similarly, mental health law may look like law and may be called law, but it is not true law. Anglo/American criminal law is a *shield* to protect the person accused of crime from the power of the state. Anglo/American mental health law is a *weapon* to protect the state from the person denominated as ''mental patient'' (as well as the ''patient'' from himself).

Nearly 300 years ago, Montesquieu (1689–1755) warned: ''There is no more cruel tyranny than that which is perpetrated under the shield of law and in the name of justice''.[20] This is perhaps even truer today, when tyranny is perpetrated not in the name of justice, but in the name of therapy.[21]

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